Healthy Child Care

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Including Children of All Abilities In Your Early Childhood Setting

Have you ever been that person left out of the group or the last one picked as a child? Have you ever been that person at one point or another when you wanted someone to stand up for you and shout to everyone that you are worthy of time, thoughts, efforts and praise?

Each day families who have children with special needs struggle to find that someone to help or to stand with them and say their child is worthy of time, thoughts, efforts and praise. As an early childhood educator you have a great opportunity to be that support by simply including children of all abilities into your daily setting.

Many early childhood providers are hesitant to be that person. Many feel they don't have the knowledge or may be uncertain of the child's needs or of their ability to guide the program they work for and the staff who work for them.

First we need to really define the word "Inclusion" and realize that it's more natural and easier than we might expect.

√ Inclusion is children with special needs being educated in Least Restrictive Environments (LRE) or Naturalistic Environments (NRE). This means that, to the maximum extent possible, these children are included with "typically developing" children in public or private institutions or facilities providing care in their own neighborhoods, schools, etc.

√ Inclusion is meeting the individual needs of each child.

√ Inclusive programs look much like any other early childhood program – representing children with and without disabilities. They have a philosophy of acceptance.

Every person who comes into contact with an inclusive early childhood program benefits in different ways; however, there are some general benefits that we all share.

All Children:

- Make diverse friendships and become part of a group;
- Accept differences within themselves and within others;
- Learn developmental & emotional skills (language, communication, patience, compassion); and
- Gain self-esteem and self-respect.

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Inside This Issue

Bureau of Child Care
Update

Bureau of Child Care
573-751-2450

Update On Licensing Rule Revisions

The Bureau of Child Care (BCC) is continuing its work on revising the licensing rules for child care homes, group child care homes and child care centers. The following will provide information about why it's important to revise the licensing rules and information about some of the proposed changes to the licensing rules.

Our current licensing rules have been in effect since 1991. The National Association for Regulatory Administration recommends that states revise licensing rules every 3 to 5 years. As you can see, Missouri is definitely due for a rule revision. Thus, the bureau began this current rule revision process.

Five workgroups, made up of child care providers, representatives from resource and referral agencies, the state Fire Marshal's office, Educare, and BCC staff, were formed to aid in the process. The workgroups met from July 2000 to October 2001 to discuss the issues and formulate general ideas for what they would like to see in the revised rules. The workgroups have now completed their work and have summitted their recommendations to the bureau.

The following are some of the **recommendations** that the bureau is considering:

- √ Counting in the capacity any related children who come into the facility for care. This would not include related children that live in the home.
- √ Requiring all caregivers to be trained in First Aid and CPR.
- √ No longer requiring annual TB testing for caregivers.
- √ Changing the underarm temperature from 100 degrees F to 101 degrees F or above before a child must be sent home or not accepted for care.
- √ Requiring new licensees to have a high school diploma or a G.E.D.
- √ Requiring all licensees to post their most recent inspection and any negative action notices.
- √ Requiring all licensees to notify the bureau of any child death; any child injury that requires emergency medical care; any child left behind; or a child who left the facility without staff's knowledge.

All licensed facilities will receive a draft of the proposed rules and will have the opportunity to express their views during a 30 day public comment period.

Please remember, *the new licensing rules are <u>not in effect</u> at this time.* Please continue to follow the current licensing rules.

The bureau would like to thank all providers who served on the workgroups and all who have taken time to provide input during this valuable process!

Partial support for this newsletter is provided by : HRSA Maternal and Child Health Bureau

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Consumer Product Safety Commission

The U. S. Consumer Product Safety Commission (CPSC) is an independent federal regulatory agency that works to reduce the risk of injuries and deaths from consumer products. You can reach the CPSC through:

- The CPSC toll-free Hotline at (800) 638-2772 or (800) 638-8270 for the hearing and speech impaired.
- The CPSC web site address at http://www.cpsc.gov

How to Obtain Recall Information

The U.S. CPSC issues approximately 300 product recalls each year, including

many products found in child care settings.

Many consumers do not know about the recalls and continue to use potentially unsafe products. As a result, used products may be loaned or given to a charity, relatives, or neighbors, or sold at garage sales or secondhand stores. You can help by not accepting, buying, lending, or selling recalled consumer products. You can contact the CPSC to find out whether products have been recalled, and, if so, what you should do with them. If you have products that you wish to donate or sell and you have lost the original packaging, contact the CPSC to find out product information.

To receive CPSC's current recall information automatically by e-mail or fax, or in a quarterly compilation of recalls sent by regular mail, call CPSC's hotline and after the greeting, enter 140, then follow the instructions given.

Each issue of this newsletter will highlight a recalled product or a safety issue; however, it would be wise to check with the CPSC on a regular basis for more comprehensive information.

CPSC, Small World Toys Announce Recall of Sorter Toys

In cooperation with the U.S. Consumer Product Safety Commission (CPSC), Small World Toys of Culver City, Calif., is voluntarily recalling about 880 sorter toys. The plastic windows on the "see-inside" sorting blocks can break, causing the beads inside to be released. This presents a choking hazard to children.

Small World has received one report of a sorter block breaking. No injuries have been reported.

The recalled "Sort & See" sorting box is made of hardwood and comes with eight shaped blocks of various colors. Each block is filled with beads that are visible through plastic windows. The wooden box has a clear plastic top and cutouts on two sides that correspond with the shapes of the blocks. The words "Ryan's Room" is printed on one side of the sorter box.

Toy stores sold the sorters nationwide from May 2002 through June 2002 for about $20.

Consumers should take the recalled shape sorters away from children immediately and return the toys to the store where purchased for a refund. For more information, consumers can contact Small World Toys toll-free at (800) 421-4153 between 8:30 a.m. to 4:30 p.m. PT Monday through Friday .

How To Reduce the Risk of Choking Accidents

Every five days one child in the United States dies from choking on food. Children under the age of five are most at risk. Young children are at a greater risk because of poor feeding practices, dangerous foods, and unsafe toys. Young children do not develop the back teeth needed to chew and grind lumps of food until around four years of age.

One of the best ways to handle a choking accident is to keep it from happening. As a caregiver of young children, follow these tips to reduce the chances of choking.

- √ Do not prop a bottle in an infant's mouth. The baby could spit up and choke. Babies are not born with the skill of swallowing and chewing. They have to learn to swallow, chew and breathe all at the same time.
- √ Always watch what and how children eat and encourage them to chew slowly and thoroughly. Foods that are too large or too hard may cause children to gag when swallowing, which could lead to choking.
- √ Make sure feeding times are quiet and still. If a child is running or playing and falls with food in his mouth, he could inhale the food and choke.

The most dangerous foods are small round items, such as popcorn, because they can block a child's airway, causing suffocation. Foods that can get stuck in a child's airway should be cut up into pieces, such as:

- √ Hot dogs – always cut hotdogs length-wise and then into small pieces.
- √ Grapes –should be cut into quarters
- √ Raw vegetables – should be cut into small strips or pieces that are not round
- √ Hard or sticky candy, like whole peppermints or caramels – should be broken or cut into small pieces
- √ Nut and seeds – should be chopped or ground
- √ Avoid feeding peanut butter by the spoon full.

These foods are dangerous not just because they are round, but also because they have smooth surfaces and can slide into the airway very easily. Safe foods for young children are crackers and small pieces of soft fruits such as banana, orange and ripe pear.

In addition, children often choke on toys. It is important that we learn to recognize dangerous toys. Balloons can be a major choking hazard for young children. Other toys to keep out of reach are small balls, marbles and toys with small parts that can break off. Parents and caregivers should scan the floor and low surfaces for buttons, beads, pins, coins, pop-tops, nails, tacks, screws, pieces of crayon, jewelry, small batteries or any other object a baby could easily pop into his or her mouth. Parents and caregivers should be firm in teaching children not to hold objects in their mouths.

What to do if a young child is choking

Check to see if the child can cough, cry or breathe. If the child is breathing, he or she may be able to dislodge the food by coughing. Do not try to dislodge the food by hitting the child on the back as this may cause the food to move to a more dangerous position and make the child stop breathing.

If the child is not breathing

- √ Try to dislodge the food by placing the child face down over your lap with the child's head lower than his or her chest.
- √ Give the child four sharp blows on the back just between the shoulder blade using enough force to dislodge the food.
- √ Check again for signs of breathing.
- √ If the child is still not breathing, call 911 and ask for an ambulance.

Of course, the most important thing to remember is that most choking incidents can be prevented. Parents and caregivers must watch children closely and keep dangerous toys, foods, and household items out of children's reach.

As the Carton Clucks...
Exposing the Risk of Salmonella Poisoning

As we return to our story, child care center director, Carla Cautious is making rounds visiting each of the classrooms in her center. She checks in the baby room. Misty Mollycoddle is rocking one baby and has another in the swing. Carla smiles and moves on to the three-year-old room. Tommy Tinytoes is about to stick a "cup" cut from an egg carton in his mouth. Carla leaps across the table just in time to make a "save."

Carla thinks to herself, "What's wrong with my staff! Don't they know that egg cartons can spread ***salmonella****?"*

Salmonella is an illness that can cause diarrhea, fever, stomach cramps, nausea, and vomiting. Symptoms usually are gone within one week, but may last as long as two weeks. Usually salmonella is acquired from contaminated food. Chicken and eggs are the foods most commonly associated with salmonella but fresh produce sometimes becomes contaminated during growing or processing.

Food poisoning from salmonella should not be a problem if all of the common food safety rules are followed.

√ All fresh produce should be washed.

√ Foods should be kept from cross contaminating each other, for example, don't let the thawing chicken drip on the strawberries.

√ Don't chop raw meat and vegetables with the same knife or on the same cutting board without thoroughly washing and sanitizing between each use.

√ Avoid holding foods in the danger zone (between 41-140 degrees F).

√ Dispose of cracked eggs.

Salmonella is in the feces of those who are ill, so hand washing is another important tool in preventing its spread. The children's hand washing should be supervised (to see they are doing an adequate job) after using the restroom. Staff persons changing diapers need to clean their hands and the baby's hands carefully before diapering another child and before returning to other activities, even if they were wearing gloves.

Animals can also spread salmonella. Reptiles are notorious for spreading salmonella. In Missouri, reptiles are not allowed in licensed facilities. Beware of children bringing baby chicks or ducks for show and tell because those sweet little babies can easily spread salmonella. Supervise all staff and children's hand washing after petting animals.

Can egg cartons spread salmonella? Maybe. According to the Center for Disease Control, there have not been any documented cases of salmonella being contracted from an egg carton craft, but why take the risk? If egg cartons must be used for a craft, then try to obtain unused cartons. Some craft stores sell them, or maybe an egg processor can donate cartons. If there are no other options but to use used egg cartons, only use the foam ones and wash then spray with a sanitizing solution. Do not use cardboard egg cartons.

Another popular egg related item for crafts are eggshells. Crunched, glued and painted eggshells make interesting textures for art projects, but their use is not recommended for the above reasons.

Betty Brainy turned around and saw Carla Cautious sprawled on the floor holding Tommy with one arm and an egg carton cup with the other hand.

Betty thinks, "I'll bet Carla doesn't know I bought those egg cartons at the craft store!"

(Continued from page 1)

Families:

- Gain the ability to work and support themselves financially;
- Become part of a community for support, information, & strength;
- Learn to accept their child's strengths and abilities & needs; and
- Develop disability awareness.

Early Childhood Educators/ Providers:

- Realize and appreciate individual differences;
- Expand professional services, resources and develop networks within the community;
- Work with a diverse group of children and families; and
- Increase their image and acquire a larger market.

Are you still wondering if you can take on a task like "Inclusion" and where would you even start? Here are a few ideas to get you started!

- *Develop an attitude of acceptance and a philosophy that reflects it.* Remember that children and families are more alike than different. Make clear statements about how you believe children learn and how your program will serve them. Policy manuals and job descriptions should reflect this attitude as well. Allow others to view your philosophy through pictures on the walls, books and other curriculum. Reflect the community you wish to serve.

- *Define lines of collaboration*
  - § Administration and staff should be working toward the same goal. Staff should receive support through workshops and training to allow them to feel comfortable.
  - § Families should feel that the program is working with them to give their child the best experience possible. Families should be able to feel a sense of trust from the program, and the program in turn should feel the same way toward the family.
  - § The program should be collaborating with community organizations to make sure they are providing quality care and developmentally appropriate practices. These organizations may include Early Childhood Special Education, Child Care Resource and Referral (Inclusion Specialists), First Steps (Missouri's early intervention program), Parents as Teachers, and Educare.

- *Begin accepting children of all abilities into your program* Remember you can get what it takes to meet each child's needs. Look to community collaborations to give you support and resources you may need.

As a summary, we must remember that an Inclusive Program is not just a facility with windows and a front door as well as a few books and pictures that represent children with different abilities. An Inclusive Program is a *feeling* of community and acceptance. It is a program in which you, the early childhood provider, accept children's individual strengths and unique needs. Remember that good early childhood programs are already doing this with "typically developing" children. If you are already doing so, it should be simply an extension of what you already provide.

Lastly, remember that children are always children before their abilities. Sitting Bull said, " Let us put our minds together and see what life we can make for our children." He did not say for children with or without disabilities, but our children.

Article provided by:
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New Resource for Reportable Diseases & Conditions

In Missouri, child care providers are required to report the presence or suspected presence of a number of diseases or conditions to their local health department or to the Missouri Department of Health and Senior Services.

In order to aid providers and others that are required to report, a one page handout has been produced. A copy of this resource can be found on pages 7 and 8 of this newsletter. You may remove these pages from the newsletter and keep them for your future reference. You may want to laminate these pages as a resource and make sure it is close at hand when you need it.

Diseases and Conditions Reportable in Missouri

Numbers represent ICD 9 and ICD 10 codes.

1. **Category I diseases or findings** shall be reported to the local health authority or to the Department of Health and Senior Services **within twenty-four (24) hours of first knowledge *or suspicion*** by telephone, facsimile or other rapid communication. Category I diseases or findings are—

(A) Diseases, findings, or agents that occur naturally or from accidental exposure:

- Diphtheria (032, A36)
- *Haemophilus influenzae*, invasive disease (038, 041.5, 320, G00.0)
- Hantavirus pulmonary syndrome (079.81, 480.8, J12.8)
- Hepatitis A (070.1, B15)
- Hyperthermia (992, T67)
- Hypothermia (991, 991.6, T68)
- Influenza, suspected nosocomial outbreaks and public or private school closures
- Lead (blood) level (≥45 µg/dl) in any person ≤72 months of age (984, T56.0)
- Measles (rubeola) (055, B05)
- Meningococcal disease, invasive (036, A39.0)
- Outbreaks or epidemics of any illness, disease or condition that may be of public health concern
- Pertussis (033, A37.0)
- Poliomyelitis (045, A80)
- Rabies, animal or human (071, A82)
- Rubella, including congenital syndrome (056, 771.0, B06, P35.0)
- *Staphylococcus aureus*, vancomycin resistant (041.1, V09.8)
- Syphilis, including congenital syphilis (090-090.9, 093-097.9, A50, A51-A52)
- Tuberculosis disease (010-018, A15-A19)
- Typhoid fever (002, A01.0)

(B) Diseases, findings, or agents that occur naturally or that might result from a terrorist attack involving biological, radiological, or chemical weapons:

- Adult respiratory distress syndrome (ARDS) in patients <50 years of age (without a contributing medical history) (518, J80)
- Anthrax (022, A22)
- Botulism (005.1, A05.1)
- Brucellosis (023, A23)
- Cholera (001, A00)
- Encephalitis, Venzuelan equine (066.2, A99.2)
- Glanders (024, A24.0)
- Hemorrhagic fever (e.g., dengue, yellow fever) (060, 061, 065.0, 065.4, 078.8, 078.89, A90, A91, A95, A96.2, A98.0, A98.3, A98.4)
- Plague (020, A20)
- Q fever (083, A78)
- Ricin (988.2, T62.1)
- Smallpox (variola) (050, B03)
- Staphylococcal enterotoxin B
- T-2 mycotoxins (T64)
- Tularemia (021, A21)

2. **Category II diseases or findings** shall be reported to the local health authority or the Department of Health and Senior Services within **three (3) days of first knowledge *or suspicion***. Category II diseases or findings are—

- Acquired immunodeficiency syndrome (AIDS) (042, B20-B24)
- Arsenic poisoning (985.1, E866.3, T57.0)
- Blastomycosis (116, B40)
- Campylobacter infections (008.43, A04.5)
- Carbon monoxide poisoning (986, T58)
- CD4+T cell count
- Chancroid (099, A57)
- Chemical poisoning, acute, if terrorism is suspected, refer to section (1)
- *Chlamydia trachomatis*, infections (099.8, A56)
- Creutzfeldt-Jakob disease (046.1, A81.0)
- Cryptosporidiosis (136.8, A07.2)
- Cyclosporidiosis (007.5, A07.8)
- Ehrlichiosis, human granulocytic or monocytic (083.8, A79.8)
- Encephalitis, arthropod-borne (062-064, A85.2)
- *Escherichia coli* O157:H7 (008.0, A04.1)
- Giardiasis (007.1, A07.1)
- Gonorrhea (098, A54)
- Hansen disease (leprosy) (030, A30)
- Heavy metal poisoning including, but not limited to, cadmium and mercury (961.2, 985.5, E866.4, T56.1, T56.3)
- Hemolytic uremic syndrome (HUS), post-diarrheal (283.11, D59.3)
- Hepatitis B, acute (070.3, B16)
- Hepatitis B surface antigen (prenatal HBsAg) in pregnant women (070.3, B16)
- Hepatitis C (070.5, B17.1)
- Hepatitis non-A, non-B, non-C (070.9, B19)
- HIV infection (042-044, B20-B24)
  HIV viral load results (including nondetectable results)
  HIV-exposed newborn infant (i.e. born to HIV+ mother)
  HIV test results for children <2 yrs whose mother is HIV+
- Influenza, laboratory confirmed (487, J10, J11)
- Lead (blood) level (≤45 µg /dl) in any person ≤72 months of age and any lead (blood) level in persons >72 months of age (984, T56.0)
- Legionellosis (482.8, A48.1)
- Leptospirosis (100, A27)
- Listeria monocytogenes *(027.0, A32)*
- Lyme disease (104.8, 088.81)
- Malaria (084, B50-B54)
- Methemoglobinemia (289.7, D74)
- Mumps (072, B26)
- Mycobacterial disease other than tuberculosis (MOTT) (031, A31)
- Nosocomial outbreaks
- Occupational lung diseases including silicosis, asbestosis, byssinosis, farmer's lung and toxic organic dust syndrome (495.0, 501, 502, 504, J61, J62, J66.0, J67.0)
- Pesticide poisoning (E863, 989.0, 989.2, 989.3, 989.4, T60)
- Psittacosis (073, A70)
- Respiratory diseases triggered by environmental contaminants including environmentally or occupationally induced asthma and bronchitis (490, 493.0, J44, J45.0)
- Rocky Mountain Spotted Fever (082, A77.0)
- Salmonellosis (003, A02.0)
- Shigellosis (004, A03.0)
- Streptococcal disease, invasive, Group A (041, 034, 035, 670, A49.1, J02.0, A38, L01.0, A46, O85)
- *Streptococcus pneumoniae*, drug-resistant invasive disease (481, J13)
- Tetanus (037, A35)
- Toxic shock syndrome, staphylococcal or streptococcal (041, 041.0, 785.5, A48.3, A49.0, A49.1)
- Trichinosis (124, B75)
- Tuberculosis infection (010-018, A15-A19)
- Varicella deaths (052, 053, B01, B02)
- *Yersinia enterocolitica* (008.44, A04.6)

Report diseases and conditions to your local health agency or to:

Missouri Department of Health and Senior Services
Office of Surveillance
by phone 800-392-0272
or by fax 573-751-6417

19 CSR 20-20.020 Reporting Communicable, Environmental and Occupational Diseases.

(1) Category I diseases or findings shall be reported to the local health authority or to the Department of Health within twenty-four (24) hours of first knowledge *or suspicion* by telephone, facsimile or other rapid communication.

(2) Category II diseases or findings shall be reported to the local health authority or the Department of Health within three (3) days of first knowledge *or suspicion*.

(3) The occurrence of an outbreak or epidemic of any illness, disease or condition which may be of public health concern, including any illness in a food handler that is potentially transmissible through food. This also includes public health threats that could result from terrorist activities such as clusters of unusual diseases or manifestations of illness and clusters of unexplained deaths. Such incidents shall be reported to the local health authority or the Department of Health by telephone, facsimile, or other rapid communication within twenty-four (24) hours of first knowledge or suspicion.

(4) A physician, physician's assistant, nurse, hospital, clinic, or other private or public institution providing diagnostic testing, screening or care to any person with any disease, condition or finding listed in sections (1)–(3) of this rule, or who is suspected of having any of these diseases, conditions or findings shall make a case report to the local health authority or the Department of Health, or cause a case report to be made by their designee, within the specified time.

(A) A physician, physician's assistant, or nurse providing care in an institution to any patient with any disease, condition or finding listed in sections (1)–(3) of this rule may authorize, in writing, the administrator or designee of the institution to submit case reports on patients attended by the physician, physician's assistant, or nurse at the institution. But under no other circumstances shall the physician, physician's assistant, or nurse be relieved of this reporting responsibility.

(B) Duplicate reporting of the same case by health care providers in the same institution is not required.

(5) A case report as required in section (4) of this rule shall include the patient's name, home address with zip code, date of birth, age, sex, race, home phone number, name of the disease, condition or finding diagnosed or suspected, the date of onset of the illness, name and address of the treating facility (if any) and the attending physician, any appropriate laboratory results, name and address of the reporter, treatment information for sexually transmitted diseases, and the date of report.

(A) A report of an outbreak or epidemic as required in section (3) of this rule shall include the diagnosis or principal symptoms, the approximate number of cases, the local health authority jurisdiction within which the cases occurred, the identity of any cases known to the reporter, and the name and address of the reporter.

(6) Any person in charge of a public or private school, summer camp or child or adult care facility shall report to the local health authority or the Department of Health the presence or suspected presence of any diseases or findings listed in sections (1)–(3) of this rule according to the specified time frames.

(7) All local health authorities shall forward to the Department of Health reports of all diseases or findings listed in sections **(**1)–(3) of this rule. All reports shall be forwarded within twenty-four (24) hours after being received according to procedures established by the Department of Health director. Reports will be forwarded as expeditiously as possible if a terrorist event is suspected or confirmed. The local health authority shall retain from the original report any information necessary to carry out the required duties in 19 CSR 20-20.040(2) and (3).

(8) Information from patient medical records received by local public health agencies or the Department of Health in compliance with this rule is to be considered confidential records and not public records.

(9) Reporters specified in section (4) of this rule will not be held liable for reports made in good faith in compliance with this rule.

AUTHORITY: Sections 192.006, RSMo Supp. 1999 and 192.020, 192.139, 210.040 and 210.050, RSMo (1994).* This rule was previously filed as 13 CSR 50-101.020. Original rule filed July 15, 1948, effective Sept. 13, 1948. For intervening history, please consult the Code of State Regulations. Amended: Filed Sept. 15, 1995, effective April 30, 1996. Emergency amendment filed June 1, 2000, effective June 15, 2000, expired Dec. 11, 2000. Amended: Filed June 1, 2000, effective Nov. 30, 2000.

*Original authority: 192.006, RSMo (1993), amended 1995; 192.020, RSMo (1939), amended 1945, 1951; 210.040, RSMo (1941), amended 1993; and 210.050, RSMo (1941), amended 1993.

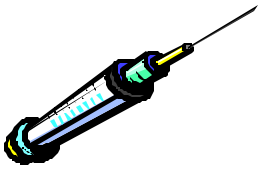
This rule can be accessed on the web at: ***www.dhss.state.mo.us/LicensingAndCertification/Rules.html***

Report diseases and conditions to your local health agency or to:

Missouri Department of Health and Senior Services
Office of Surveillance
930 Wildwood, P.O. Box 570
Jefferson City, MO 65102
PHONE: 800/392-0272 FAX: 573/751-6417

This publication may be provided in alternative formats such as Braille, large print, and audiotape by contacting the office listed above. TDD users can access the above phone number by calling 800-735-2966.

Questions & Answers About Adult Immunizations



National Adult Immunization Week will be held from October 13-19, 2002. The purpose of this event is to educate and raise awareness of the importance of adult immunizations. Each year in the United States, up to 60,000 adults die from vaccine-preventable diseases or their complications. Pneumonia and influenza together are the seventh leading cause of death in the United States and the fifth leading cause of death among older adults.

Consider the following information from the National Coalitions for Adult Immunizations:

√ Up to half of Americans over 50 years of age are inadequately immunized against tetanus and diphtheria.

√ Forty to fifty cases of tetanus occur each year, resulting in an average of 5 deaths annually in the United States. Most deaths occur in those 60 years of age or older.

√ Almost all reported cases of tetanus occurred in persons who have either never been vaccinated or who completed their primary series but have not had a booster vaccination in the past 10 years.

√ Nearly one out of every 10 people who gets diphtheria will die from it.

√ People of any age can get measles, but those born after 1956 who do not have proof of immunity or proof of having had the disease are particularly at risk and should be immunized.

√ More than 200,000 Americans are infected with hepatitis B each year. The majority are adolescents and young adults.

√ The hepatitis B virus is found in blood and other body fluids. It is 100 times more infectious than HIV, the virus that causes AIDS.

The following are questions and answers related to adult immunizations:

Are there vaccines that protect adults against diseases?
Yes! Immunizations are readily available for such common adult illnesses as influenza (flu), pneumococcal disease and hepatitis B. Vaccinations against measles, mumps, rubella (German measles), hepatitis A, tetanus (lockjaw), diphtheria and varicella (chickenpox) are also needed by some adults.

The federal Advisory Committee of Immunization Practices recommendations clearly identify people who are at risk for these diseases and who should be immunized to prevent these diseases and their complications. Consult your healthcare provider or local health department regarding your own immunization status and recommendations for immunizations.

Why immunize?
Some of these illnesses, once contracted, do not have a cure, and all may cause tremendous health problems or even death. Vaccines are some of the safest medicines available, are very effective, and can relieve suffering and costs related to these preventable diseases for us all.

Should all adults be immunized? Yes.

√ All adults require tetanus and diphtheria immunizations at 10 year intervals throughout life.

√ Adults born after 1956 need to be immunized against measles, mumps and rubella.

√ All adults aged 65 or older, as well as persons aged 2-64 years who have diabetes or chronic heart, lung, liver or kidney disorders need protection against pneumococcal disease and should consult their healthcare providers regarding their need for this shot.

√ Influenza vaccination is recommended for adults 50 years of age or older, pregnant women and residents of long-term care facilities, as well as for persons older than six months of age who have chronic illness and persons six months-18 years of age who receive chronic aspirin therapy.

√ Hepatitis B vaccine is recommended for adults in certain high-risk groups, such as healthcare workers and persons with multiple sex partners.

(Continued on page 10)

Hepatitis B vaccine is also recommended for all adolescents who may not have not received it during infancy or childhood.

Many adults, including teachers of young children and day care workers, who have not had chickenpox and have not been immunized previously against chickenpox, should receive varicella vaccine.

How often do I need to be immunized?

√ Immunizations for pneumococcal disease (except for patients at particular risk for pneumococcal complications) offer protection for life.

√ Persons born after 1956 require a second measles vaccination.

√ Influenza vaccine must be administered yearly because immunity wanes after a few months and due to the appearance of new strains of virus which are not addressed by previous vaccines.

√ Booster doses of tetanus and diphtheria vaccines (usually given as a combination Td vaccine) are required every 10 years to maintain immunity against these diseases.

√ Two doses of measles, mumps and rubella vaccine, given at least 30 days apart, are recommended for maximum effectiveness.

√ Hepatitis B vaccine is administered in three doses given over a six month period.

√ Two doses of chickenpox vaccine are recommended for people 13 years or older who have not had the disease.

√ Two doses of hepatitis A are needed six to 12 months apart to ensure long-term protection.

Are there side effects to these immunizations?
Vaccines are among the safest medicines available. Some common side effects are a sore arm or low fever. As with any medicine, there are very small risks that serious problems could occur after getting a vaccine. However, the potential risks associated with the diseases these vaccines prevent are much greater than the potential risks associated with the vaccines themselves.

Should I carry a personal immunization record?
Definitely yes! A permanent immunization record should be kept by every adult. It will help you and your healthcare provider ensure that you are fully protected against vaccine-preventable diseases. It can also prevent needless revaccination during a health emergency or when you change providers. Ask your provider for an immunization record, and be sure to take it with you to every time you visit so it can be reviewed by your provider and updated each time you are immunized.

CACFP Training Schedule

Orientation training for the Child and Adult Care Food Program for childcare centers* is held in the five district offices located throughout the state.

Northwestern District
Independence
October 15
November 12
December 10

Southwestern District
Springfield
October 15
November 12

Southeastern District
Cape Girardeau
October 18
December 13

Central District
Jefferson City
October 22
December 19

Eastern District
St. Louis
October 11
November 15

*Shelter and After-school training held separately.

Call 800-733-6251 to register for a training session in your area.

National Coalition for Adult Immunization
4733 Bethesda Avenue, Suite 750
Bethesda, MD 20814-5228

Grant Available for Start-Up or Expansion of Child Care Facilities

The Missouri Department of Social Services, Division of Family Services has issued a Request for Proposal RFP 200207, for the Start-up of new or expansion of existing child care facilities. The RFP has been posted on the Internet and applications can be submitted on-line. You will find a link to the grant application at www.dss.state.mo.us/dfs/early. If you are interested in submitting a competitive application and you do not have Internet access, you may obtain a copy of the application by calling the Division of Family Services, Early Childhood Unit at 573-522-1385.

It is an expectation of this grant that the program will pursue accreditation by an early childhood accrediting model recognized by the Department of Social Services. By the end of the third year of this grant, grantee programs must be engaged in the self study process for accreditation. Upon renewal for third year funding, the Department of Social Services will assist grantee programs in locating resources to help with the accreditation process.

Programs targeting children birth to three years of age must agree to serve a minimum of four children. If a program is expanding, the program must agree to add a minimum of ten children to the licensed capacity.

Competitive grants are available for varying amounts from $20,000 to $100,000 for applicants who are serving a minimum of 25% of Division of Family Services subsidized children and are:

- √ Starting-up a new child care program and are new to the community or unlicensed and will pursue licensing with this grant; **or**
- √ Expand an exising child care program by increasing capacity.

It should be noted that those people with a copy of the application will not have access to certain edits that are available when using the on-line version. There may be resources in your community to assist you in accessing the Internet, such as public libraries, local Division of Family Services offices, Community Action agencies, etc.

Applications must be received no later than 3:00 p.m. on October 31, 2002.

Paper copies must be mailed to:
Division of Family Services Attention: Larry Martin
Contract Management Unit
P.O. Box 88
Jefferson City, MO 65103

or delivered to:
Contract Management Unit
615 Howerton Court
Jefferson City, MO 65109.

Applicants are cautioned that mail received at the Division's "Post Office Box 88" address may not be delivered to the Division's Contract Management Unit on the day it is received. Therefore, applicants should mail their applications well in advance of the date applications are due at the division.

Applications sent by overnight delivery should be delivered to the Division at 615 Howerton Court, Jefferson City, MO 65109. On-line and paper applications must reach the Division of Family Services Contract Management Unit before 3:00 p.m. on October 31, 2002 or they will not be considered.

For more infomation please contact:
Cindy Reese or Becky Houf
DFS, Early Childhood Unit
573-522-1385

Team Up for Fire Safety

Fire Prevention Week will be held October 6-12, 2002. This year's theme is "**Team Up for Fire Safety.**" The theme's intent is for fire departments to be the center of the public safety team with participation from everyone to help ensure families and communities are safer. The campaign involves these essential safety lessons: 1) install and test smoke alarms; 2) practice home escape plans; 3) hunt for home hazards.

Statistics indicate that children and the elderly are among the higher risk groups for fire-related injuries and death. It is important to involve children in interactive and fun activities that teach them key fire safety lessons.

The National Fire Protection Association's website, www.nfpa.org provides a wide variety of fire prevention tools and ideas. Here is related information from the NFPA :

√ A home fire is reported in the U.S. approximately every 1- 1 ½ minutes. Someone in the U.S. dies in a home fire approximately every 30 minutes.

√ Three in every ten home fires start in the kitchen. Cooking fires are the number one cause of home fires and home fire injuries.

√ Cigarettes and other smoking materials are the number one cause of home fire deaths.

√ Heating equipment fires are the second leading cause of home fires and related deaths.

√ Smoke alarms listed by a qualified testing laboratory are the most effective warning device available. Having working smoke alarms in your home cuts the chance of dying in a fire nearly in half.

Please make every effort to provide fire prevention lessons to children year round, not just during Fire Prevention Week.

MISSOURI DEPARTMENT OF HEALTH
& SENIOR SERVICES
BUREAU OF CHILD CARE
P.O. BOX 570
JEFFERSON CITY MO 65102-0570

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